State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	**Please complete in triplicate (type if possible) Mail two copies to:**	**OSHA CASE NO.**
		FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported**

EMPLOYER

1. FIRM NAME — 1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip) — 2a. Phone Number
3 .LOCATION, (if different from Mailing Address (Number, Street, City and Zip) — 3a.Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc. — 5. State unemployment insurance
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School Dist ☐ Other Gov't, Specify: _____

INJURY

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)	8. TIME INJURY/ILLNESS OCCURRED AM PM	9. TIME EMPLOYEE BEGAN WORK AM	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE ☐ Yes ☐ No	12. DATE LAST WORKED (mm/dd/yy)	13. DATE RETURNED TO WORK (mm/dd/yy)	14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST ☐ Yes ☐ No	16. SALARY BEING CONTINUED? ☐ Yes ☐ No	17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)

ILLNESS

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)	20a. COUNTY	21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.	23. Other Workers Injured/Ill in this event? ☐ Yes ☐ No	

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold:

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED , e.g.. Welding seams of metal forms, loading boxes onto truck.

26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.

27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)	27a. Phone Number
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ No ☐ Yes If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip).	28a. Phone Number
	29. Employee treated in Emergency Room ☐ Yes ☐ No

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2

EMPLOYEE

30. EMPLOYEE NAME	31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City, Zip)		33a. PHONE NUMBER
34. SEX: ☐ Male ☐ Female	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)	36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS hours per day, days per week, total	37a. EMPLOYMENT STATUS ☐ regular, full- ☐ part-time ☐ temporary ☐ seasonal	37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38. GROSS WAGES/SALARY $ _____ per	39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses) ☐ Yes ☐ No	

Completed By (type or print)	Signature & Title	Date (mm/dd/yy)

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim: and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

Please do not use this	
CASE NUMBER	
OWNERSHIP	
INDUSTRY	
OCCUPATION	
SEX	
AGE	
DAILY HOURS	
DAYS PER WEEK	
WEEKLY HOURS	
WEEKLY WAGE	
COUNTY	
NATURE OF INJURY	
PART OF BODY	
SOURCE	
EVENT	
SECONDARY SOURCE	
EXTENT OF INJURY	